Dental Billing FAQ

FAQs compiled from the Dental Webinar held Tuesday, September 21, 2021.

Q: How do I determine which dental Medicaid plan to bill to, DentaQuest or Delta dental?

A: The first step in determining dental coverage is to verify member eligibility through the Community Health Automated Medicaid Processing System (CHAMPS). For step-by-step instructions reference this Member Tab Quick Reference Guide. After determining members' eligibility for dental services (i.e., managed care or fee for service) reference the Dental Responsibilities at a Glance resource. This resource details the dental vendor and contact information.

Q: If a patient receives a COVID-19 vaccine during a dental visit. What claim form do we use? Dental claim form with dental insurance or a medical claim form with medical insurance?

A: A COVID-19 vaccine cannot be given in a dental office during a dental visit. However, if a beneficiary is seen at a clinic where dental and medical services are performed there is the possibility that both services could be done on the same day at the same location. In this instance, correct billing guidelines should be followed, as the COVID-19 vaccine would fall under the medical benefit not the dental. If additional information is needed, please email ProviderSupport@michigan.gov.

Q: How do we get away from sending in the paper prior authorization form?

A: A dental prior authorization (PA) can be entered via direct data entry (DDE) through CHAMPS. For step-by-step instructions on entering a DDE PA through CHAMPS reference the CHAMPS Prior Authorization presentation.

Q: I am having trouble with claims that are denied for primary and upon investigation find that they do not have a primary? How can this be taken off of CHAMPS to get claims paid?

A: If a beneficiary says they do not have primary coverage and CHAMPS indicates they do, the beneficiary must contact their caseworker to have the primary removed. Reference Billing Alert posted, June 24, 2019:

> Updating TPL: As a reminder, when the Third-Party Liability (TPL) information is reported incorrectly in CHAMPS by the insurance companies listed below, please contact them directly to update their records. If the insurance company makes corrections, they will send the update to TPL.

- BCN
- BCBSM
- McLaren
- Priority Health
- Administration Systems Research (ASR)
- Physician's Health Plan (PHP)
- Medimpact
- Express Scripts
- OptumRX
- Delta Dental

To report TPL (Add, Change, or Termination) for other insurance companies that are not listed above, please submit a request to TPL by completing the online DCH-0078 form before submitting a claim to Medicaid.

Q: We continuously have problems billing Medicaid secondary claims to CHAMPS. We have attempted billing the claims online but continue to see rejections for lack of information from primary insurance adjustments.

A: Providers are encouraged to reference the step-by-step instructions for Direct Data Entry for Dental Claims >> Adding Primary Insurance and the Michigan Medicaid Provider Manual>>Chapter Coordination of Benefits>>Section 1.3 Verification of Other Insurance. However, if a provider continues to have unresolved claims contact Provider Support at 1-800-292-2550 or by email ProviderSupport@michigan.gov.

Q: Can prior authorizations be completed online for Medicaid patients?

A: Yes, prior authorizations can be completed online via DDE through CHAMPS. For step-by-step instructions on entering a DDE PA through CHAMPS reference the CHAMPS Prior Authorization presentation.

Q: When submitting a secondary claim through CHAMPS, what is required as supporting documentation for Max Reached claims that come from the primary. We have 100's of outstanding claims that we are struggling to get paid for and are consistently getting different answers from Provider Support.

A: It is important to review denied claims and inquire to Provider Support as soon as possible (i.e., before 60 days). During this time a new claim does not need to be submitted. When the primary reports the benefit max has been reached and Medicaid denies the claim, a provider should upload the primary's EOB stating where payment was made and where the benefits were maxed, into the Document Management Portal (DMP). Reference the DMP Upload Instructions for assistance. Once the documentation

has been uploaded into DMP contact Provider Support where they will review the documents and send them over to the Other Insurance Claims Unit for further review.

Q: Will you please remind me the time frame for submitting a crown/denture/RCT if a member has a prior authorization and then bene's coverage is termed before delivery?

A: If a beneficiary's eligibility has been termed and services were already started but not completed, services must be completed by the last day of the following month. For additional information please refer to the Michigan Medicaid Provider Manual, Billing and Reimbursement for Dental Providers, Section 5.2 Loss or Change in Eligibility.

Q: We have payments from our primary insurance and are attempting to cross over the balance to Medicaid, we have spoken to customer support for help with these claims but continue to have problems.

A: Providers are encouraged to reference the step-by-step instructions for Direct Data Entry for Dental Claims >> Adding Primary Insurance and the Michigan Medicaid Provider Manual>>Chapter Coordination of Benefits>>Section 1.3 Verification of Other Insurance. However, if a provider continues to have unresolved claims contact Provider Support at 1-800-292-2550 or by email ProviderSupport@michigan.gov.

Q: How are Physician activations communicated to the other dental payers i.e., Delta Dental, DentaQuest, Molina, or United Healthcare?

A: If you would like to provide services for Medicaid beneficiaries, please enroll within the Community Health Automated Medicaid Processing System (CHAMPS). Visit the Provider Enrollment website for step-by-step enrollment instructions. Providers who are interested in joining a specific network, need to follow up with that network for enrollment requirements.

Q: When submitting a secondary claim to CHAMPS that has been denied with a CARC 96, we are now being asked to provide an EOB from the primary payer. Is this something that is going to be necessary for all CARC 96?

A: Yes, if the primary rejects a claim with a CARC 96 and had previously made a payment on that particular procedure code the claim will be denied. When this happens, an EOB is to be uploaded to the Document Management Portal (DMP). Reference the DMP Upload Instructions for assistance. Once the documentation has been uploaded into DMP contact Provider Support where they will review the documents and send them over to the Other Insurance Claims Unit for further review.

Q: If a claim remains suspended for over 60 days before being processed will that come back to us to resubmit, or will they continue to process?

A: If a claim has been suspended for longer than 60 days contact Provider Support following the claim inquiry requirements to have the claim reviewed. During this time (i.e., claim status suspended) Providers should not rebill a new claim as it will be denied for a duplicate.

Q: If CHAMPS shows an HMP active & the HMP denies due to pt. having straight Medicaid - how do we get the coverage updated & the claim paid? Example: CHAMPS shows Delta HK active-Delta HK states inactive.

A: Email an inquiry to Provider Support at ProviderSupport@michigan.gov following the claim inquiry requirements.

Q: How do we get a claim paid when the Healthy Michigan Plan (HMP) states the Doctor is not registered/enrolled, yet the doctor is registered/enrolled with Michigan Medicaid?

A: After a provider has verified the enrollment status of an NPI utilizing the Provider Verification Tool and the HMP continues to deny the claim please email an inquiry to Provider Support at ProviderSupport@michigan.gov following the claim inquiry requirements.